



P.O. Box 440 • 1434 Progress Lane
 Omro, Wisconsin 54963-0440
 Telephone (920) 685-5662 • Fax (800) 541-5967

*** 1 DOCTOR - ORDER BLANK ***
GEORGIA STANDARD FORMAT
PRESCRIPTION FORM

If Reorder - Prev. Job # _____ Start # 00001

ORDER DATE _____ DEALER P.O. _____ CUSTOMER P.O. _____
 DEALER NAME _____ DEALER # _____ SIGNATURE _____
 ADDRESS _____

SHIPPING INFORMATION: _____

STYLE

- 1 Part PC4-GA
- 2 Part PC4-GA2
(Second Part Blank)

QUANTITY

- 10 Pads 20 Pads
- 40 Pads 60 Pads
- 80 Pads 120 Pads
- 240 Pads

Optional Copy

- DOB M/F Spanish Refill Void After Qty. Boxes
- Prescription is void if more than one (1) controlled substance is written per blank.
- _____ Prescription is void if the number of drugs prescribed is not noted.

HOMETOWN CLINIC
John Doe, M.D.
Family Practice
 1234 Your Address
 YourCity, GA 98765
 (987) 654-3210
 Fax (987) 654-3211

110922A12345 #00001

Name _____ DOB _____

Address _____ Date _____ M/F _____

Lic. #: A12345
 DEA #: AA7654321
 NPI #: 789456123

SEE BACK FOR LIST OF SECURITY FEATURES

Rx

Refill NR 1 2 3 4 5 Void After _____ Spanish

Do Not Substitute-Dispense As Written

Signature

COMPLETE INFORMATION IS REQUIRED BEFORE ORDER WILL BE ENTERED.

PRACTICE NAME _____
 PHYSICIAN NAME _____
 SPECIALTY _____
 ADDRESS (No P.O. Box Allowed) _____
 CITY _____ STATE **GA** ZIP _____
 PHONE _____ FAX _____
 DEA # _____ LICENSE # _____ NPI # _____
 PHYSICIANS SIGNATURE _____ (Or Authorized Employee)

- Please provide proof
 - Mail Fax _____
 - Email _____

ADDITIONAL CHARGE OPTIONS

- Imprint Part 2 Pad in 50's
- Padded Wraparound Cover Stapled Wraparound Cover



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***MULTI DOCTOR / MULTI ADDRESS
 ORDER BLANK ***

**GEORGIA STANDARD FORMAT
 PRESCRIPTION FORM**

If Reorder - Prev. Job # _____ Start # 00001

ORDER DATE _____ DEALER P.O. _____ CUSTOMER P.O. _____

DEALER NAME _____ DEALER # _____ SIGNATURE _____

ADDRESS _____

STYLE 1 Part PC4-GA 2 Part PC4-GA2
 (Second Part Blank)

QUANTITY 10 Pads 20 Pads 40 Pads 60 Pads
 (Pads of 100) 80 Pads 120 Pads 240 Pads

Optional Copy

- DOB M/F Spanish Refill Void After Qty. Boxes
- Prescription is void if more than one (1) controlled substance is written per blank.
- _____ Prescription is void if the number of drugs prescribed is not noted.

SHIPPING INFORMATION:

PRACTICE NAME _____

DOC. 1 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 2 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 3 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

DOC. 4 _____ SPECIALTY _____

DEA # _____ LICENSE # _____ NPI # _____

ADDRESS 1 _____

CITY 1 _____ STATE 1 **GA** ZIP 1 _____

PHONE 1 _____ FAX 1 _____

ADDRESS 2 _____

CITY 2 _____ STATE 2 **GA** ZIP 2 _____

PHONE 2 _____ FAX 2 _____

ADDRESS 3 _____

CITY 3 _____ STATE 3 **GA** ZIP 3 _____

PHONE 3 _____ FAX 3 _____

ADDRESS 4 _____

CITY 4 _____ STATE 4 **GA** ZIP 4 _____

PHONE 4 _____ FAX 4 _____

- Please provide proof
 - Mail Fax _____
 - Email _____

ADDITIONAL CHARGE OPTIONS

- Imprint Part 2 Pad in 50's
- Padded Wraparound Cover Stapled Wraparound Cover

MAXIMUM OF 5 LINES